

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/17/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505092	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/04/2014
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NAME OF PROVIDER OR SUPPLIER ALDERWOOD PARK HEALTH AND REHABILITATION	STREET ADDRESS, CITY, STATE, ZIP CODE 2726 ALDERWOOD AVENUE BELLINGHAM, WA 98225
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Survey conducted at Alderwood Park Convalescent Center on 11/03/14 and 11/04/14. A sample of 7 residents was selected from a census of 90. A sample included 5 of current residents the record of 2 former and/or discharged residents.</p> <p>The following complaints were investigated as part of the survey:</p> <p>3048883 3048682 3049045 3050208 3049544 3048719</p> <p>The survey was conducted by:</p> <p>Nadyne Krienke, R.N., M.S.N.</p> <p>The survey team is from:</p> <p>Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, Region 3, Unit B 3906 172nd Street NE, Suite 100 Arlington, WA 98223</p> <p>Telephone: (360) 651-6850 Fax: (360) 651-6940</p> <p><i>Marilyn Ferguson Wolf</i> Residential Care Services Date</p>	F 000	<p><u>Disclaimer Clause</u></p> <p>Preparation and/or execution of this plan of correction does not constitute the provider's admission of or agreement with the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>N.L. Graham</i>	TITLE <i>Administrator</i>	(X6) DATE <i>12/19/14</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to timely notify the physician regarding a change in condition 1 of 7 residents (1). Failure</p>	F 157	<p>F 157</p> <p><u>Plan of Correction</u></p> <p>Resident #1 discharged to the hospital on [REDACTED] and did not return to the facility.</p> <p>An audit of current facility resident's has been conducted to assure physician and responsible parties have been notified of changes in condition.</p> <p>An in-service has been conducted for facility nursing staff on prompt notification of physician and responsible party for changes in condition.</p> <p>An audit of the 24-hour report, incident log, and physician order changes will be conducted by the DON/Designee weekly to assure changes in condition were reported appropriately. Trends identified will be reported to the QAPI committee monthly and as needed until a lesser frequency is deemed appropriate.</p>	12/24/14

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F 157	<p>Continued From page 2</p> <p>to notify Resident 1's physician resulted in a delay in evaluation and treatment. Findings include:</p> <p>The facility's policy for physician contact, dated 2001, directed LNs to contact the physician for input on the care of residents. The type of reasons for contact included mental level changes, change in resident condition. The policy directed staff to document when the physician was contacted and the reason.</p> <p>The hospital's history and physical, dated 10/15/14, revealed Resident 1 had a recent paracentesis (a procedure to remove fluid from the abdomen). The hospital note revealed 16 liters was drained from the abdomen and his ammonia level was elevated at 110 (normal ammonia level range 11-32).</p> <p>Resident 1 was admitted to the facility on [REDACTED] with diagnoses including [REDACTED]. The admit nursing assessment revealed the resident was alert, with confusion and forgetful. The assessment documented his abdomen was distended and abdominal girth measured 103 centimeter (cm). The nursing notes, dated 10/23/14, documented he was ambulating independently, was alert and orientated, continent of bowel and bladder (B&B) and able to feed himself.</p> <p>On 10/24/14, the following day, the resident was unable to take liquids, was disoriented, confused, unable to follow simple directions and/or perform self-care. The note read he was incontinent of Bowel and bladder and unable to sit up in bed.</p>	F 157		

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F 157	<p>Continued From page 3</p> <p>On 10/24/14, Speech therapy (SLP) evaluated Resident 1. The SLP's note documented the resident "presents with mild oral dysphagia (difficulty swallowing), needing assistance with cues to clear oral residue, remember to swallow in order to decrease minimal risk of aspiration, presents with moderate cognitive-communication deficit, with notable confusion, perseveration on tasked, difficulty following simple functional 1 step direction, naming items, attention to task, and orientation deficient". The SLP directed staff to staff to use simple one step directions, tactile cues and to change his diet texture to a mechanical soft texture.</p> <p>There was no documented evidence the Licensed Nurses (LNs) had notified the physician regarding the change in Resident 1's mentation, decreased swallowing ability with a need for a diet change.</p> <p>On 10/26/14, a nursing note entry indicated Resident 1's medication was held as the LN was unable to wake the resident and "briefly open eyes". The day shift LN documented the resident had spit out all medication, had decreased level of consciousness with "no responsive verbal, performed sternal rub, patient slightly open eye, unable to follow commands, no hand grips, patient started to repeat yes multi times, raised both arms, and dropped. The LN notified the charge nurse (CN) who assessed the resident at 10:00 a.m.</p> <p>On 10/27/14, his abdominal girth had increased to 108 cm and he was observed to ambulate without assistance at times.</p> <p>There was no documented evidence, the LN or CN had reported or notified Resident 1's</p>	F 157		

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F 157	<p>Continued From page 4</p> <p>physician regarding the fluctuation in mentation, difficulty swallowing, inability to administer oral medications and/or increased abdominal girth.</p> <p>On 10/28/14, the physician (MD) visited the resident. The note indicated Resident 1 ' s ascites " had not recurred since discharge from the hospital and hepatic encephalopathy seems to have resolved " .</p> <p>On [REDACTED] at 11:00p.m., Resident 1 was sent to hospital via 911 for non-responsive, non-alert, eyes were open but no response, extremities very cool to touch and abdominal distension was noted. The MD was notified and Resident 1 was sent out.</p> <p>On 11/04/14, at 9:00 a.m., during an interview, LN M stated Resident 1 had an episode of being unresponsive. LN M further stated he had notified his CN who assessed the resident and determined that the resident was "exhausted". LN M stated he had not notified the physician regarding the condition change.</p> <p>The emergency room (ER) notes, dated [REDACTED] documented Resident 1 had decreased/altered mental status and " only withdrew from pain today " . The ER note revealed he opened his eyes to pain and had no verbal response. The ammonia level was elevated at 294 (normal 11-32).</p> <p>On 11/04/14, the Acting Director of Nursing verified the facility failed to communicate with the physician regarding condition changes in mentation, urinary status, and ability to eat and not have his routine medication for his medical condition.</p>	F 157		

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F 157	Continued From page 5 On 11/17/14 at 8:17 a.m., during an interview, the resident's physician stated she had not been notified by the LNs or CN regarding the resident's swallowing difficulties requiring a diet change with 1:1 supervision on 10/24/14 or Resident 1's unresponsiveness and a need to perform a sternal rub on 10/26/14, the inability to administer oral medications prescribed and/or his increased abdominal girth on 10/27/14.	F 157		